

- SUBJECT:** Adopting the Interstate Health Care Compact
- COMMITTEE:** State Sovereignty, Select — favorable, without amendment
- VOTE:** 5 ayes — Creighton, Branch, Darby, S. Miller, Pitts
0 nays
2 absent — Martinez Fischer, Thompson
- WITNESSES:** For — Mario Loyola, Texas Public Policy Foundation; (*Registered, but did not testify:* Brent Connett, Texas Conservative Coalition; Jonathan Saenz, Liberty Institute)

Against — Anne Dunkelberg, Center for Public Policy Priorities; (*Registered, but did not testify:* Jean Thomas Dwyer, Daughters of Charity Advocacy and Social Justice Committee; Shannon Jones; Rick Levy, Texas AFL-CIO; Tim Morstad, AARP)

On — (*Registered, but did not testify:* Jeff Miller, Disability Rights Texas)
- BACKGROUND:** The U.S. Constitution, Article 1, sec. 10, clause 3 prohibits states, without the consent of Congress, from entering into agreements or compacts with other states or a foreign power.
- DIGEST:** CSHB 5 would amend the Insurance Code to place into law the provisions of an Interstate Health Care Compact and to direct Texas to join the compact with other states to secure from the federal government primary responsibility to regulate and improve health care by its own legislature. A “member state” would be a state that signed the compact and had adopted it under its laws. The bill would define health care to include a wide range of services, including preventive, therapeutic, physical or mental health, pharmacy, and individual or group health plans, except for plans provided by the U.S. Department of Defense and U.S. Department of Veteran Affairs or for Native Americans.

The bill would authorize Texas, as a member state, to suspend by legislation the operation of all federal laws, rules, and regulations that were inconsistent with the state’s health care laws and regulations. Federal

laws and regulations would remain in effect unless suspended, and Texas would be responsible for funding any unsuspended federal health care law or rule in effect after the compact's effective date.

The bill would provide that Texas as a member state would have the right to federal money up to an amount equal to its federally funded mandatory health care spending in fiscal 2010 and adjusted by factors that took into account changes in the state's average population as determined by the U.S. Bureau of the Census and inflation as measured using a Total Gross Domestic Product Deflator determined by the U.S. Department of Commerce.

The bill would create the Interstate Advisory Health Care Commission, whose membership would be determined by each member state and would be funded as agreed to by the member states. Texas, as a member state, could not appoint more than two members and could withdraw membership at any time. The commission would be required to collect information to assist member states in their health care regulation and to share their information with the member states' legislatures. The commission could study health care regulation issues and make nonbinding recommendations. The commission could have other responsibilities and duties as conferred by the member states' legislatures.

Member states by unanimous agreement could amend the compact, and the amendment would remain in effect unless Congress disapproved the amendment within one year. Texas, as a member state, could withdraw from the compact by adopting a law, but the withdrawal could not take effect until six months after the governor had informed the other member states.

The bill would take immediate effect if finally passed by a two-thirds record vote of the membership of each house. Otherwise, it would take effect on the 91st day after the last day of the legislative session.

The bill provides that Texas would agree that the compact's effective date would be the later of the date the compact was adopted under Texas law or the date the compact was adopted by at least two states and received consent of the U.S. Congress. The compact would not take effect if, in consenting to the compact, Congress altered the compact's fundamental purposes.

SUPPORTERS
SAY:

Federal health care requirements are driving rising and unsustainable state expenditures that are “breaking the bank” of Texas and other states. Medicaid spending, in particular, has grown by more than 170 percent over the last decade. State spending will grow exponentially when federal health care reform takes effect and an additional 2.1 million Texans become eligible for Medicaid by 2019. Medical inflation is far outpacing population growth. Texas must wrest control of health care spending and chart its own course that better responds to its unique demographic, geographic, and economic characteristics. A health care compact between Texas and at least one other state would allow us to gain this control.

The U.S. Constitution authorizes interstate compacts, which take the place of federal law. More than 200 compacts now exist to help states address a range of issues, including transportation, supervision of former prisoners, and low-level radioactive waste disposal, and offer unused potential for other activities, including health care. Congress would have to enact a law to give consent to the compact, but no other legislation would be needed. Its approval of the Washington Metropolitan Area Transit Authority compact shows precedent for approving a compact that provides for the suspension of certain federal laws.

An interstate compact would preserve federalism by allowing each member state to create a health care system that aligned with its needs. Texas needs to use all legal tools at its disposal to protect areas of authority traditionally reserved for states and the health care interests of Texans.

The bill would initiate the state’s membership into a potential compact and not bind its participation. The state could withdraw at any time because the controlling provisions on withdrawal would be entirely specified within the compact.

Texas’ control of health care regulation and programs would allow the state to apply innovative approaches and tailor programs to meet specific state needs. Federal Medicaid requirements are a “one-size-fits-all” kind of approach that leaves little room for innovation. Federal maintenance of effort requirements prohibit Texas from making changes that would tailor Medicaid eligibility or make other meaningful reforms.

The compact would allow Texas to choose which federal programs it wanted to suspend, and Texas could choose to keep in place programs that

were popular, such as Medicare, if warranted. Seniors may have paid into Medicare through their payroll taxes, but Medicare also is funded by other tax revenue, and the compact would give Texas the flexibility and control to assure that all Medicare spending was appropriate and in the best interest of Texans. Among the options would be to contract with the federal agency that now administers Medicare to assure program continuity, if warranted. Additional controls on Medicare would help prevent the federal government from shifting to the states the entire cost of care for individuals who were both Medicare and Medicaid eligible, which are now being split among the programs. Appropriate and effective use of the state's authority under the compact would be further assured by the enactment of HB 32, which would establish a committee to examine and make recommendations about the state's capability to assume regulatory authority over health care.

Making meaningful changes would not mean reducing eligibility for publicly funded health care services, but participation in the compact would allow the state to better evaluate and respond to priority needs and populations. By redirecting funds from less important services or overly restrictive or prescriptive regulatory requirements, we can meet current eligibility levels, improve provider rates, and build health care capacity in other areas.

HB 5 would ensure adequate federal funding to meet changing capacity and service needs because the compact appropriately would calibrate Texas' share of federal funding to account for population growth and inflation. By establishing 2010 as a baseline year, federal funding would be pegged to the year when Texas enjoyed its highest federal matching rate for Medicaid due to federal stimulus funding. It is uncertain whether Texas in subsequent years would forgo additional funding related to federal health care reform because of the compact, since health care reform is being challenged by several states and entities and ultimately may be invalidated or repealed.

Congress is too distant and gridlocked to devise laws and regulations that respond to issues as personal as health care. These decisions should be made as close to home as possible, by Texans for Texans. Furthermore, the continually soaring U.S. deficit calls into question the reliability of any future federal funding and the wisdom of relying on the federal government for health care spending or solutions.

Fears of Texans having reduced access to safe, quality health care when compared to other states are unwarranted. The bill specifically states that member states would pledge to improve health care policy within their jurisdictions. The bill also would require states' federal funding to be audited by the U.S. Government Accountability Office.

The health care compact would be governance reform, not health care reform, and would leave health care policy decisions entirely in the hands of Texas. The compact would allow Texas to provide safe, high-quality health care in a fiscally responsible way under the control of state lawmakers who were more responsive, accountable and accessible to Texas citizenry, and able to increase marketplace competition and options. Texas could set health care service standards other states may want to emulate.

Congress would have trouble saying no to a compact that was enacted by several states. Legislatures in many more states are now considering participation in the compact. Georgia and Oklahoma already have adopted the compact. The Missouri legislature also has approved the compact, and the legislation is awaiting the governor's signature. At the very least, enactment of this bill by Texas and other states would require Congress to better address states' demands for more state control. For example, state demands were critical in reforming welfare programs in the 1990s.

OPPONENTS
SAY:

Rising state health care expenditures are largely related to population growth, health status, aging, and the emergence of new technologies and therapies. Increased health spending in both the public and private sectors is nothing new, and it has typically outpaced economic growth since the 1960s. Since the interstate compact proposed by HB 5 could not slow these trends, and Texas has continuously implemented reforms to contain Medicaid costs and incentivize innovation, the most likely result of Texas' participation in the compact would be kicking low-income, often aged or unhealthy, and mentally, developmentally, or physically disabled people off of much-needed, federally supported health care services.

The bill would not require Texas to build capacity to meet the needs of its population, and therefore would not guarantee that Texas would have a better health care system or would keep eligibility standards in place. Medicaid eligibility in Texas is among the lowest in the U.S., and with 6.4 million uninsured people, many are now going without needed health care.

It is unrealistic to believe that under the compact's funding scheme, Texas would have the financial resources to be able to extend and improve services or keep eligibility levels. This session, the Legislature was unable to create a budget for fiscal 2012-13 that meets current service levels on most health and human service programs. Any increase in capacity would be financed solely by state dollars, since the compact would lock Texas' federal funds at a 2010 level that would adjust only for growth and inflation. Since Texas' current Medicaid expenditures are well below the national average, we would receive less initial funding relative to other states. Additionally, the funding formula would mean Texas would lose about \$120 billion in new federal funds related to health care reform.

This bill could jeopardize Medicare, which is a crucial health care support for seniors of all income levels. Medicare is a program that people earn by paying into it during their working years, and it should not be tampered with. Texas has no experience administering Medicare, and even if it kept federal Medicare laws and rules in place, it would still be responsible for running and funding it. Keeping Medicare a federally run and funded program also will help seniors maintain a similar level of quality care, regardless of where they moved or traveled within the United States. No serious federal proposals exist to pass onto states the entire cost of individuals called "dual eligibles," whose health care costs are now shared by Medicare and Medicaid. The only proposals recently considered have been to shift the entire cost of dual eligibles to the federal government.

It would be irresponsible of Texas legislators to agree to this unprecedented compact that could bind Texas to an unknown fate. The governor of Arizona on April 18 wisely vetoed that state's compact bill, citing the likelihood that that the state's citizens, especially seniors, would be penalized if the state assumed control of health care spending from the federal government. The governor of Montana on May 12 also vetoed a bill seeking to adopt the compact, stating that it was "a frivolous measure that does nothing at best, and at worst puts seniors, Montanans with disabilities, and children at risk."

Interstate compacts do not replace or nullify federal law, but are designed to facilitate states' interactions in common regulatory activities. An interstate compact has never been used for health care. Congress does not relinquish any powers by consenting to a compact. It is unclear whether Congress could consent to this compact without passing legislation

authorizing states to suspend federal law and whether Texas could unilaterally withdraw from a congressionally approved compact without approval of Congress.

Suspending federal health care laws and regulations could endanger the health of Texans and create a lower level of health care for Texans when compared to residents of other states. Federal health care regulations provide the most equitable basis for health service access for all U.S. citizens and often are needed as a check and balance to lapses in state regulation or enforcement.

OTHER
OPPONENTS
SAY:

This bill is more a political and symbolic exercise against recent federal actions than a realistic way of addressing our health care expenditures. The chances are slim that Congress would approve a compact that required it to give money to states without directing its spending. The Texas Legislature directs all spending of state tax dollars because it is the prudent and fiscally responsible way to manage money, and Congress should be expected to act similarly. There is no reason to believe that state lawmakers would be more responsive or fiscally responsible than members of the U.S. House or Senate.

NOTES:

With the exception of the effective date, HB 5 is identical to HB 5 by Kolkhorst from the regular session of the 82nd Legislature, which passed the House on April 21 by 104-41 and was reported favorably, without amendment, by the Senate Health and Human Services Committee on May 11, but died on the Senate Intent Calendar.

The House on June 8 adopted an amendment by Rep. Kolkhorst identical to HB 5 to SB 7 by Nelson. The Senate has refused to concur with House amendments and has appointed conferees.

HB 32 by Zerwas, which would create a committee to study and make recommendations to the governor and the Legislature about the most efficient use of the authority provided by an interstate health care compact, was referred to the House Appropriations Committee on June 2.